

Danbury Hospital Updates its Case Management Program

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Getting physicians to buy into a totally new approach to case management is a formidable task, especially when the purpose of the change is to forge a real-time partnership with the physician. Instead of forcing a system on physicians, however, Matthew Miller, MD, VP of Medical Affairs and Beth Kelly, Director Of Case Management at 320-bed Danbury Hospital in Danbury CT. planned a strategy to design a program that treated the physicians like the key customers they are.

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To overcome anticipated resistance to a change in the physicians comfort level with the existing program, Miller and Kelly interviewed physicians to pinpoint exactly what changes in operational processes would make their time in the hospital hassle-free. They found out that delay in scheduling diagnostic procedures, treatments and results reporting topped their list of frustrations. In addition, Miller and Kelley asked what activities physicians valued most from a case manager. Among the frequently heard responses were accurate information about payer issues, transition planning options and potential obstacles, liaison to translate information to the family, and facilitator of treatment plan.

Using these preliminary customer-focused goals to kick off the project, Kelly put together a design team to begin the process of converting Danbury's classical case management program into a more responsive clinical resource management program. Kelley's staff of case managers and social workers had established an enviable track record of length of stay reductions, but costs per case and third party denials remained a major challenge for the organization.

The team met weekly with the assistance of an outside consultant, to create a framework for the new program that would extend the customer focus to include payers and patients as well as the physicians. The team wanted to create a new structure that would be customer-friendly in general and hassle-free for the physician. They wanted the physician to be able to boast about his experience at Danbury. Once consensus was reached among the medical and executive leaders regarding the primary purpose and goals of the new program. There were three stages

top the redesign process. Planning a new structure, engaging the customer, and implementing tools and strategies.

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Building the Social Structure.

One of the primary goals of the new program was to reduce the number of individuals with whom each customer had to interact to get information. The team quickly realized that to achieve that goal, they had to consolidate or integrate many over-lapping activities that were traditionally the domain of other disciplines. For example, in the past, retrospective interactions were common between a medical records coder and the physician about a possible modification to physician's documentation to more accurately reflect the patient's severity of illness. Under the new program, retrospective physician interaction was viewed as an intrusion that had to be eliminated or at least minimized. That meant the case managers had to take on the responsibility of providing real-time documentation advise to the physician at the point of care. In addition, a streamlined structural framework meant that many of the legacy activities that had been assumed to be the responsibility of the case managers in their previous life had to be returned to the process-owners. For instance, a respiratory therapist monitoring oxygen therapy during the course of the acute care stay has to be responsible for a seamless handoff to his counterparts in the home care company. Ongoing communication with the case manager to determine to determine the payer's preferred provider and targeted transition day was essential for this change-over to succeed.

The new program was horizontally positioned with the performance improvement and medical staff credentialing under the administrative umbrella of the VP of Medical Affairs. Previously decentralized social workers were centralized under the new Clinical Resource Management (CRM) Program to be deployed according to the patient needs and priorities rather than geographical assignments. Social Workers would be a key resource for the clinical resource manager if the patient required intensive psychosocial counseling to support continuity of care goals. Since the social workers would no longer be the primary discharge planner, they were able to refocus their practice to address psychosocial counseling, family support and self-care compliance issues.

In the end, many negotiated trade-offs were achieved and the case manager now known as a clinical resource manager, was positioned as the single source of continuity information for the hospital's key customer.

Engagement

The team explored a wide universe of strategies to engage the primary customers in this new process of clinical resource management. They also acknowledge that colleagues and peers both within the hospital and Danbury's integrated delivery system were customers in addition to being essential participants in the new RM process. It was clear to the team members that to achieve their goals and truly streamline the patient care delivery program every staff member had to become a street-level marketing agent for the clinical resource managers. Five key strategies were promulgated to survive the new program hospital wide:

1. Data, rather than anecdotal incidents would be used exclusively to document opportunities to improve internal and external processes. The data would be captured and analyzed by the CRM staff and reported to each hospital department.
2. The new role of Clinical Resource Manager (CRM) would be positioned to cultivate a collegial rather than a competitive relationship with internal colleagues and peers. The CRM would supplement the established roles and responsibilities but would not interfere.
3. Every challenge will be addressed from the perspective of the customer's expectations.
4. The CRM would establish a meaningful partnership with his or her assigned physicians, building credibility, dependability and reliability, and would eventually use this relationship to influence practice behaviors in a manner that would reduce financial, clinical and quality risks to the patients, the payers, the hospital and the physician.
5. Accountability for the linkages to external resources in the Danbury system or the community would be facilitated by the clinical resource manager, though responsibility would remain in the hands of the process owners.

Data became key for many of the new program's initiatives, and discussions with the business office, managed care contract department and the CFO proved beneficial. With the assistance of their consultant, the Danbury design team was able to identify several resources essential for the CRM's daily work activities. In the end, several data capture and reporting processes were either streamlined or created to generate the information needed to support the CRM program. This included information on payer reimbursement methodologies, monthly reports on actual write-offs due to payer denials, hospital acquired complication rates, and readmission rates and several external measures to share with process owners whose services impact the efficient journey of the patient through the acute care continuum.

Implementation Preparations

The design team ended up planning a series of initiatives to support a comprehensive clinical resource management program. The entire package was presented to the medical and executive leadership, who gave it their stamp of approval but suggested a gradual implementation to reduce the anticipated confusion of such a dramatic change in the organization's operating style. New job descriptions were created emphasizing competencies in information systems, managed care, reimbursement processes, accurate documentation, and other business-related skills. The candidates had to be "clinically competent" to discuss practice alternatives with the physician and had to be able to demonstrate risk-taking behaviors. The new role emphasized relationship marketing and minimized task responsibility. The HR department endorsed the job descriptions and each incumbent had to apply if they were interested. The CRM clerical staff had to learn and adapt to new job expectations to support the work of the CRM. Perfunctory chart reviews, form completion, data entry, and report generation were among the new competencies they had to perform.

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Kelly successfully negotiated for new office space for the entire department located in an easily accessible suite off the main lobby. Concurrent to these operational activities, Dr. Miller was working with the medical staff leaders to design new evidence-based protocols with process and outcome indicators defined by a consensus of experts within the organization. Both Kelly and Miller spent time making presentations on the new clinical resource program to various committees, ancillary departments, nursing staff and medical staff divisions. Ultimately, they made a presentation to the JCAHO surveyors who were duly impressed with the scope of the program and its wide-reaching implications on performance improvement.

It was determined that the program would be implemented in phases covering selected service lines. The CRMs selected for those areas met with their assigned physicians and clarified their roles and what the physicians could expect. Finally the CRMs attended a five-day orientation program designed and presented by their consultants, who exposed

them to the business of health care and introduced them to new communication and negotiation skills. The consultants served as on-the-job- preceptors to the new CRMs for the first few days before turning over the important role of transition coach to Kelly and her assistant Pat Morgan. The success of the transition was summed up by one of the staff members who had previous roles as a utilization review nurse and case manager. As a Clinical Resource Manager she said, “ I was busy all day working with the physicians and the nurse, and even spoke with a payer and didn’t have to look at a chart even once!”

Conclusion

Although the Danbury program is in its infancy and kinks are still being resolved, the response from the medical staff has been exceptionally positive, and anecdotal feedback from patients has been glowing (Press-Ganey has agreed to modify the post-hospitalization survey to incorporate a CRM section for objective feedback). Data capture and analysis is underway and reports from the business offices on payer denials are starting to regularly appear. Kelly is secure in her belief that program outcomes will more than pay for the significant investment made to modernize the program for the new millennium.